Instructions

1. Employee must complete Employee Information.

2. Complete this Request for Reimbursement Form in its entirety. Please ensure your supporting documentation clearly indicates the requested amount.

3. Check the appropriate box in the Supporting Documentation section and submit Acceptable Supporting Documentation as described below. (When attaching small receipts, we suggest you tape them to a standard size sheet of paper.) Send copies of supporting documentation along with this form. Keep original receipts and other documents for your records.

   a) For office visits – An Explanation of Benefits (EOB) statement from your insurance carrier, OR an itemized receipt or bill from the provider that includes the provider's name, patient's name, a description of the service, the original date of the service*, and your portion of the charge.

   b) For prescription drug purchases – A pharmacy statement or receipt from your pharmacy including the patient's name, the Rx number, the name of the drug, the date the prescription was filled, and the amount.

   c) For over-the-counter (OTC) medicines – A written OTC prescription along with an itemized cash register receipt that includes the merchant name, name of the OTC medicine or drug, purchase date, and amount, OR a printed pharmacy statement or receipt from a pharmacy that includes the patient's name, the Rx number, the date the prescription was filled, and the amount.

   d) For over-the-counter health care-related products – An itemized cash register receipt with the merchant name, name of the item/product, date, and amount.

   Please Note: Credit card receipts, canceled checks, and balance forward statements do not meet the requirements for acceptable documentation.

4. Sign and date Employee Certification.

5. Submit reimbursement form and copies of supporting documentation to CONEXIS Flexible Benefits Services:

   By Fax: (877) 864-9555

   By Mail: P.O. Box 226190
   Dallas, TX 75222

Si necesita ayuda en español para entender este documento, puede solicitar sin costo adicional, llamando al número de servicio de cliente que aparece en la parte posterior de su tarjeta de identificación o en la parte inferior de la presente carta.

*The date of service, not the date of payment, must fall within the plan year for which you enrolled and while you are a participant in the plan.

Employee Information

Employer Name _____

Employee Name _____ Account Number / SSN _____

Street Address _____ Daytime Phone Number _____

City _____ State _____ ZIP _____

Do you want to know if CONEXIS received and processed your claim? Please provide your e-mail address:

E-mail Address _____

Claim Information

Patient Name	Date of Service	Type of Service	Requested Amount
			$
			$
			$
			$
			$
		Total Amount Requested (continue on additional page if necessary)*	$

Supporting Documentation

Attach Supporting Documentation (*see list of acceptable documentation)

☐ I have attached copies of Explanation of Benefits (EOBs) for deductible and co-insurance requests.

☐ I have attached itemized bills and/or itemized receipts for eligible expenses not covered by medical, dental, or vision insurance.

Employee Certification

- I certify the expenses listed for reimbursement are eligible health care expenses under the Internal Revenue Code and my employer's Flexible Benefits Plan ("Plan");
- I certify the services listed above have been received by me, my spouse, or my eligible dependent(s) on the dates indicated;
- I certify these expenses have not been submitted previously for reimbursement under the Plan and such items have not and will not be covered by any other plan or program of any employer or other person;
- I certify the services listed above were not purchased with my CONEXIS Benefit Card (if applicable);
- I understand my employer does not accept responsibility for direct payment to any individuals other than the employee;
- I understand the expenses reimbursed may not be used to claim any federal income tax deduction or credit;
- I understand any unused contributions will be forfeited to my employer at the end of the plan year;
- I understand that I may be required to provide further details about some expenses, including a statement from a medical practitioner certifying that the expense is for a specific medical condition;
- If my employer has adopted a grace period, I understand eligible expenses incurred and approved during a grace period will be paid first from any available amounts remaining in the plan year to which the grace period applies and then from the current plan year. If claims are submitted out of order, CONEXIS will provide a one-time reallocation at the end of the run-out period;
- In the event of an erroneous or excess reimbursement, I understand I am required to reimburse the Plan for the improperly paid amount. I further understand failure to repay the Plan could result in adverse income tax consequences;
- By providing my e-mail address, I authorize CONEXIS to send account information to me via e-mail.

_____ _____

Employee Signature Date

Medical expenses which have been reimbursed under this plan are not deductible for income tax purposes.

* Only the total amount supported by the attached documentation (receipts) will be paid.

Fax: (877) 864-9555 Phone: (877) 864-9549